KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
TIMOTHY J. MCDONOUGH
Deputy Attorney General
State Bar No. 235850
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2134
Facsimile: (510) 622-2270
E-mail: Tim.McDonough@doj.ca.gov
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANGELA RAE HENRY** **1831 B. Beaver Street** **Santa Rosa, CA 95404** **Registered Nurse License No. 650669** Respondent.	Case No. 2013-234 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about January 7, 2005, the Board of Registered Nursing issued Registered Nurse License Number 650669 to Angela Rae Henry (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on April 30, 2014, unless renewed.

///

////

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in relevant part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in relevant part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b) of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in relevant part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states, in relevant part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

11. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

DRUG STATUTES

12. Dilaudid is a brand name for Hydromorphone. Hydromorphone is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J), and a dangerous drug as designated by Business and Professions Code section 4022.

13. Hydrocodone is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(I) or a schedule III controlled substance if containing acetaminophen as designated by Health and Safety Code section 11056(c)(3-5), and a dangerous drug as designated by Business and Professions Code section 4022.

14. Percocet is a Schedule II controlled substance containing oxycodone and acetaminophen as designated by Health and Safety Code section 11055(b)(1)(M) and is a dangerous drug according to Business and Professions Code section 4022.

15. Oxycodone is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b)(1)(M) and is a dangerous drug according to Business and Professions Code Section 4022.

COST RECOVERY

16. Section 125.3 provides, in relevant part:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . ., upon request of the entity bringing the proceedings, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

. . .

"(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement."

BACKGROUND

17. In September 2010, Respondent was working as a Registered Nurse at Petaluma Valley Hospital (PVH), in Petaluma California. On September 22, 2010 and September 23, 2010, administrators from PVH conducted a routine audit of narcotic inventory. The audit revealed 10 oxycodone tablets were missing and unaccounted for on the unit which Respondent was working. As a result, an audit was conducted of narcotic administration by nurses working on the unit. The audit showed Respondent's narcotic withdrawal from the Pyxis machine was statistically higher than other nurses on the unit. Respondent's patient charting was reviewed for the period between September 4, 2010, and September 22, 2010. This review revealed approximately 38 discrepancies regarding Respondent's removal of narcotics from the Pyxis machine and her charting of the administration or waste of the narcotic medications. Administrators at PVH

confronted the Respondent about the discrepancies. Although Respondent denied diverting narcotics, her employment was terminated on October 9, 2010.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
(Business and Professions Code Section 2761, subdivision (a)(1))

18. Respondent has subjected her Registered Nurse license to disciplinary action under section 2761, subdivision (a), as defined by Code section 2761, subdivision (a)(1) (incompetence, or gross negligence in carrying out usual certified or licensed nursing functions), in that she repeatedly made documentation errors and failed to properly chart or record the administration, waste, or return of controlled substances regarding nine patients[1] in September 2010. The circumstances are as follows:

Patient A

19. Patient A had a physician's order for two Percocet (5 mg) as needed every three hours for moderate to severe pain. Respondent failed to properly document the administration of this medication on the following days and times.

a. On or about September 4, 2010, at 3:44 p.m., Respondent removed two 5 mg tablets of Percocet from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

b. On or about September 4, 2010, at 7:14 p.m., Respondent removed two 5 mg tablets of Percocet from the Pyxis machine. However, Respondent documented the administration of one 5 mg tablet but failed to document the administration of the remaining 5 mg tablet.

c. On or about September 5, 2010, at 3:35 p.m., Respondent removed two 5 mg tablets of Percocet from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

///

///

///

[1] For purposes of confidentiality the patients are referred to as patients A-N throughout this accusation.

Patient B

20. Patient B had a physician's order for Norco 5/325 mg as needed every four hours for moderate pain and Norco 10/325 mg every four hours as needed for severe pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 4, 2010, at 5:36 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

b. On or about September 5, 2010, at 5:49 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

c. On or about September 5, 2010, at 9:43 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to specifically document its administration on the Medication Administration Report (MAR). Respondent did not document its waste or return. There was, however, an unsigned entry on the Pain/Comfort Assessment Flow Sheet dated September 5, 2010, at 10:00 p.m., which shows that Norco was administered but it does not show its affect on the patient's pain.

Patient C

21. Patient C had a physician's order for one tablet of Percocet as needed every four hours for pain scale levels of 3-6. The physician's order also included an order for two tablets of Percocet as needed every four hours for pain scale levels 7-10. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 4, 2010, at 6:02 p.m., Respondent removed two tablets of Percocet from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

Patient D

22. Patient D had a physician's order for one 5 mg tablet of Norco every three hours for moderate pain and two 5 mg tablets every three hours for severe pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 22, 2010, at 5:26 p.m., Respondent removed two 5 mg tablets of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

Patient E

23. Patient E had a physician's order for one 5 mg tablet of Norco as needed every four hours for mild pain and two 5 mg tablets of Norco as needed every four hours for severe pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 10, 2010, at 5:21 p.m., Respondent removed two 5 mg tablets of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

Patient F

24. Patient F had a physician's order for 10 mg of Oxycodone Immediate Release (Roxicodone) as needed every fours hours for moderate to severe pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 8, 2010, at 4:41 p.m., Respondent removed two 5 mg tablets of Roxicodone from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

b. On or about September 9, 2010, at 4:18 p.m., Respondent removed two 5 mg tablets of Roxicodone from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

c. On or about September 10, 2010, at 5:41 p.m., Respondent removed two 5 mg tablets of Roxicodone from the Pyxis machine. However, Respondent failed to document the administration waste, or return of the medication.

d. On or about September 10, 2010, at 8:55 p.m., Respondent removed two 5 mg tablets of Roxicodone from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

///

Patient G

25. Patient G had a physician's order for Dilaudid 1 mg IV as needed every two hours for severe pain, one 5 mg tablet of Norco every three to four hours for mild pain, and two 5 mg tablets of Norco as needed every three to four hours for moderate pain. Respondent failed to properly document the administration of these medications on the following days.

a. On or about September 22, 2010, at 7:37 p.m., Respondent removed 1 mg of Dilaudid from the Pyxis machine. Respondent failed to document the administration, waste, or return of the medication on the patient's Medication Administration Record. However, the Pain/Comfort Assessment Flow Sheet indicated Respondent documented the administration of .5 mg Dilaudid at 8:00 p.m. Respondent failed to document the administration, waste, or return of the remaining .5 mg of Dilaudid on any of the patient's medical records.

b. On or about September 22, 2010, at 7:38 p.m., Respondent removed two 5 mg tablets of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

c. On or about September 22, 2010, at 9:19 p.m., Respondent removed 1 mg of Dilaudid from the Pyxis machine. Respondent failed to document the administration, waste, or return of the medication on the Patient's MAR. However, the patient's Pain/Comfort Assessment Flow Sheet indicated the administration of .5 mg Dilaudid at 9:20 p.m.. Respondent failed to document the administration, waste, or return of the remaining .5 mg of Dilaudid.

Patient H

26. Patient H had a physician's order for one tablet of Percocet every six hours for moderate pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 8, 2010, at 6:26 p.m., Respondent removed one 5 mg tablet of Percocet from the Pyxis machine. Respondent indicated on the MAR that the medication was not given due to "PCA Somulent" but failed to document the return or waste of the medication.

b. On or about September 9, 2010, at 6:35 p.m. Respondent removed one 5 mg tablet of Percocet from Pyxis machine. Respondent failed to document the administration, waste, or return of the medication.

Patient N

27. Patient N had a physician's order for one 5 mg tablet of Norco as needed every four hours for mild to moderate pain and one 10 mg tablet of Norco as needed every four hours for moderate to severe pain. Respondent failed to properly document the administration of this medication on the following days.

a. On or about September 14, 2010, at 3:59 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of this medication.

b. On or about September 14, 2010, at 6:12 p.m., Respondent removed two 5 mg tablets of Norco from the Pyxis machine. Respondent failed to document the waste or return of the medication.

c. On or about September 15, 2010, at 3:59 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

d. On or about September 15, 2010, at 6:36 p.m., Respondent removed one 10 mg tablet of Norco from the Pyxis machine. However, Respondent failed to document the administration, waste, or return of the medication.

SECOND CAUSE FOR DISCIPLINE
(False Entry in Medical Records)
(Business and Professions Code Section 2762, subd. (e))

28. Respondent has subjected her license to disciplinary action under section 2762, subdivision (e) (falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries), in that Respondent failed to properly document the administration and waste of narcotics in patient records. The circumstances involving improper documentation and waste of narcotics in patient records are explained in paragraphs 18 through 27, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 650669, issued to Angela Rae Henry;

2. Ordering Angela Rae Henry to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: October 02, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2012900855
90257794.docx